2011 ANNUAL REPORT

Health Care for the Homeless Network

Edward Thomas is a former client of the Medical Respite program, and the namesake of the newly opened Respite program at Jefferson Terrace.

Public Health
Seattle & King County

Acknowledgements

We gratefully acknowledge the following for their support in 2011:

HCHN Contract Partners
Country Doctor Community Health Centers • Evergreen Treatment Services • HealthPoint Neighborcare Health • Pioneer Square Clinic – Harborview Medical Center • Salvation Army – William Booth Center • Seattle Indian Health Board • University of Washington Adolescent Medicine • Valley Cities Counseling & Consultation • YWCA Seattle | King | Snohomish

Public Health - Seattle & King County
Downtown Public Health Dental Clinic • Downtown Public Health Center • Emergency Preparedness • King County Medical Examiner's Office • Public Health Centers and the Community Health Services Division • Robert Clewis Center and the HIV/AIDS Program South King County Mobile Medical Program • Tuberculosis Control Program

HCHN Funders
City of Seattle Human Services Department • King County Veterans and Human Services Levy • King County Mental Illness and Drug Dependency Sales Tax • Phoebe W. Haas Charitable Trust • United Way of King County • U. S. Dept. of Health & Human Services, Health Resources and Services Administration, Bureau of Primary Health Care • U. S. Dept. of Housing & Urban Development • Washington State Department of Health

Edward Thomas House Medical Respite Partners
Evergreen Hospital • Harborview Medical Center • St. Francis Hospital, Franciscan Health System Swedish Medical Center • University of Washington Medical Center • Valley Medical Center • Virginia Mason Medical Center • United Way of King County • King County Department of Community & Human Services-Mental Illness and Drug Dependency Action Plan • Community Health Plan of Washington • Seattle Housing Authority • American Recovery and Reinvestment Act of 2009

In-Kind Support
HCHN Planning Council members (Appendix A) • Homeless service agencies throughout King County (Appendix B) • National Health Care for the Homeless Council • Seattle-King County Coalition on Homelessness • Small Changes

In Memory

In December 2011, Suzanne Wolf, a mental health provider on the HCHN Harborview Downtown Program's Mental Health Team, passed away. For many years Suzanne worked tirelessly and imaginatively at the YWCA's Angeline's Day Center and with the Evergreen Treatment Services' REACH Team, serving the needs of homeless men and women in Seattle. She maintained her wonderful spirit during the years she struggled with her disease and its treatment. We will miss Suzanne's energy, dedication and commitment.

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Letter from Public Health's Medical Director

Greetings,

The 2011 Health Care for the Homeless Annual Report relates the progress, successes, and challenges of the work of the King County Health Care for the Homeless Network (HCHN). The work is challenging, but not nearly as challenging as the lives of those HCHN providers help to serve and care for. This report is released in a time of uncertainty and change. Will the economy improve to the point that those hardest hit will start to see some improvement? How, when city, county and federal budgets remain challenged, will the health and social service safety net continue to support those most in need? How will health care reform be implemented in our state?

While time will answer these questions, we know with certainty that too many people are living homeless. The most recent One Night Count found 2,514 people living homeless and outside of shelters or transitional housing, a 3% increase over 2011. When survival is the priority, taking care of one's health and wellness often takes a backseat. The providers serving people living homeless know this. They find and engage people where they are and connect them to services when they are ready, a critical component to serving the most disenfranchised of our community. This report highlights some of the innovative approaches being used to serve people with complex medical, mental health, and chemical dependency issues.

The report also discusses of some of the changes health care reform will bring. The anticipated changes have unleashed creative thinking among service providers and funders, which is helping to inform current work while planning for the future. It has been a busy and productive year.

Still, challenges remain. There are disproportionate numbers of people of color living homeless, and people living homeless have much shorter life expectancies than those who are housed. These disparities are longstanding and will take a collective and committed effort to reverse.

It is my pleasure and privilege to work with the dedicated and committed HCHN service providers. I respect and share their commitment to change. It is my job to support and advocate for the services they provide and the critical work that they do. It is my, and I would venture to say all of our responsibility, to work for a world where Healthcare for the Homeless services are no longer needed.

Sincerely,

Charissa Fotinos, MD

Mission

To provide quality, comprehensive health care for people experiencing homelessness in King County and to provide leadership to help change the conditions which deprive our neighbors of home and health.

Overview

Health Care for the Homeless Network (HCHN), a program of Public Health – Seattle & King County, is pleased to present highlights of its 26th year of providing health service coordination for people living homeless in King County.

The HCHN service model provides client-centered care intended to promote dignity, empower participants, and improve health and housing outcomes. Program success depends on the ability to tailor relationships, interventions, staff, and services to the individual participant, family, or community. Staff and programs recognize the importance of providing integrated care through interdisciplinary treatment teams that assure access to and coordinate primary medical and dental care, access to a health care home, mental health and substance use treatment, affordable housing, food programs, family and community support, and benefits and entitlements. Contracted staff positions include nurses, mid-level providers, physicians, mental health case managers, chemical dependency providers, and benefits specialists.

In 2011, HCHN contracted close to $6 million to community providers to increase access to care (See Appendix B for a list of partner agencies). HCHN providers visit over 60 homeless sites throughout King County (see Appendix C). HCHN also provides medical, dental, and case management services for homeless people through Public Health's centers and programs.

As a community convener, HCHN is responsible for determining the needs, gaps, and model for these services. HCHN is the only special population Bureau of Primary Health Care grantee for homeless health services in King County. This project is responsible for providing technical support to all of the Public Health centers and to community contractors to ensure understanding of Bureau requirements and to assure access to these services by homeless clients.

Between contracted services and services provided in Public Health Centers, more than 21,000 homeless people are served every year. In 2011, HCHN contractors provided 53,123 health care visits to over 9,600 unduplicated homeless individuals, and Public Health Centers provided 47,200 health care visits to 11,523 homeless individuals throughout King County.

HCHN's Philosophy of Care guides service delivery throughout the network. In keeping with this approach, HCHN providers deliver services that incorporate client-centered care, harm reduction and trauma–informed approaches, and utilize motivational techniques that consider people's

cultural traditions, personal preferences and values, family circumstances, and lifestyles. They adapt their practice to consider the special challenges faced by homeless people that may limit their ability to adhere to a plan of care. Included in this report are stories that illustrate these evidence-based approaches and how providers *turn theory into practice.*

Of the clients served across all HCHN projects in 2011, 43% were people of color, and 48% lacked medical coverage of any kind. In 2011, with assistance from HCHN providers:

- 1,606 people linked to primary care services
- 215 people linked to Regional Support Network tiered mental health services (http://www.kingcounty.gov/healthservices/MHSA.aspx)
- 557 people linked to chemical dependency treatment
- 2,262 people linked to dental services at the Downtown Public Health Dental Clinic
- 2,590 households completed Medicaid and other entitlement applications

Looking forward - The Affordable Care Act and the HCHN role in the expansion of Medicaid health coverage and delivery system reforms

Implementation of the Affordable Care Act (ACA) and the anticipated expansion of the Medicaid program stand to dramatically improve health coverage among homeless and other low-income people in King County beginning in 2014. Public Health projects that from 65,000-95,000 additional county residents will enroll in Medicaid by 2019. HCHN research has identified a conservative estimate of 7,000 currently uninsured homeless people in King County, primarily single adults, who will become eligible. Many of the newly eligible are expected to have complex health care needs, including substance abuse and mental health issues. One of HCHN's most immediate priorities is to accelerate its assertive outreach and Medicaid enrollment assistance activities targeted to these complex populations.

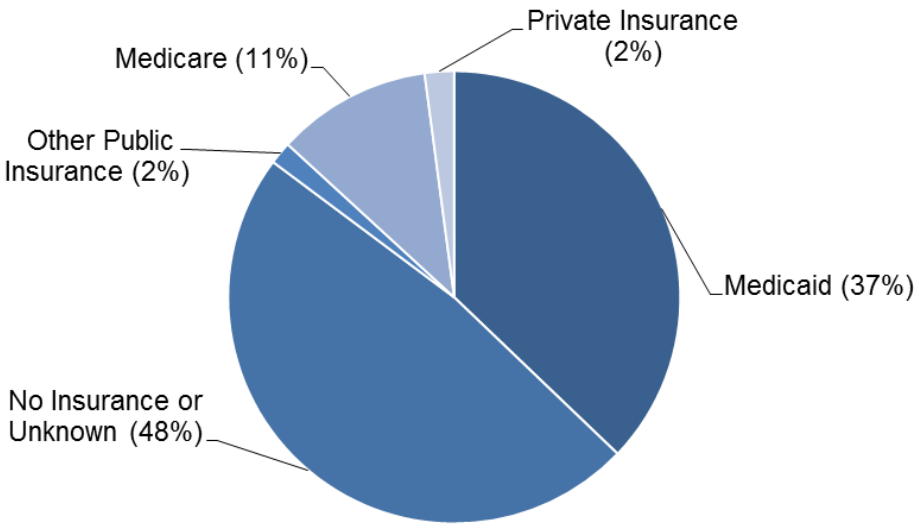
Nearly half of HCHN's 9,600 clients were uninsured in 2011, and it is anticipated that most will meet the new Medicaid eligibility requirements since the majority have incomes below what will be the new Medicaid threshold of 133% of the federal poverty level. Those with incomes above that level will be eligible for subsidies in the health benefit exchange. The expertise of HCHN providers to locate and develop trusting relationships with clients is essential to supporting those individuals through the enrollment process. Living homeless is chaotic and stressful, and people will need extended assistance connecting to benefits and care, in addition to dealing with complex barriers that can prevent them from maintaining coverage and relationships with primary care givers.

HCHN's model of care is well aligned with delivery system reforms that Washington State seeks to advance, especially those focused on high-cost, high need populations with multiple chronic health conditions. Through its partnerships, HCHN has in place an existing infrastructure of inter-disciplinary teams that reach out to people on the streets, in shelters, at feeding programs, and in homes to build trusting relationships and help coordinate their medical, behavioral health, long-term care, social service, and housing needs. As more of the population becomes covered under Medicaid and connected to managed care organizations, HCHN will work with community partners to assure a rational, effective model of care management for homeless people that is efficient and non-duplicative, that builds on existing successful models including those described in this report, and that is supported through Medicaid reimbursement for eligible functions. Aligning the HCHN care model in the larger context of delivery system reforms will allow us to help take maximum advantage of the power of the Affordable Care Act in improving the health outcomes and lowering per capita costs of one of the most vulnerable segments of our community.

HCHN has and will continue to focus on these changes in order to understand, anticipate and participate in community conversations about how to ensure access for those who do not benefit from coverage expansion under health reform - undocumented immigrants - and communicate with safety net partners and decision makers about such impacts.

Chart 1 (below) displays Medical coverage of HCHN clients in 2011.

Chart 1: Medical coverage for HCHN clients 2011 (n=9,609)

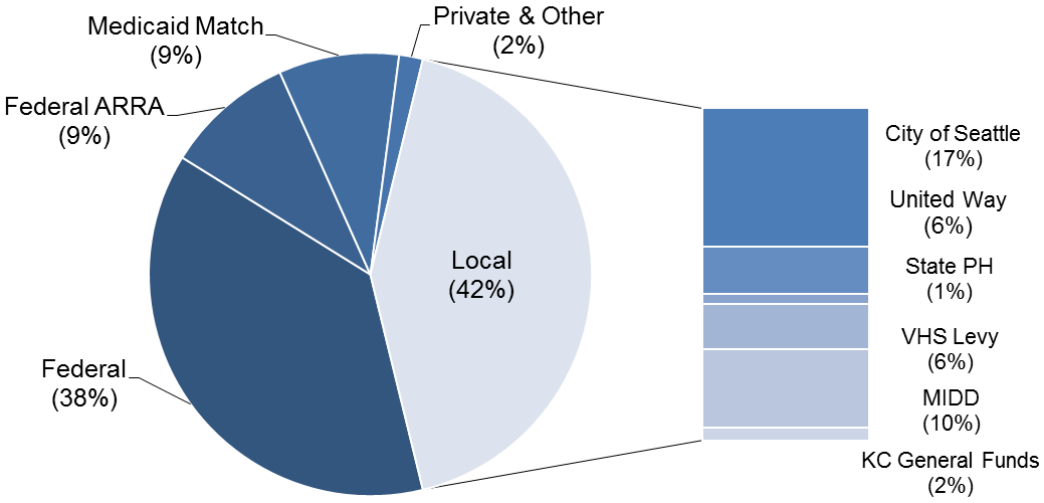


Program resources

In 2011, HCHN managed $9.2 million in funds from primarily local and federal sources. HCHN's main federal revenue source is a 330(h) Health Care for the Homeless grant, renewed annually, though the Health Resources and Services Administration (HRSA). Housing and Urban Development (HUD) funds are also designated annually for the Medical Respite program and the Pathways Home Medical Case Management program for families. Local funds (city, county and state) comprise 42% of the budget.

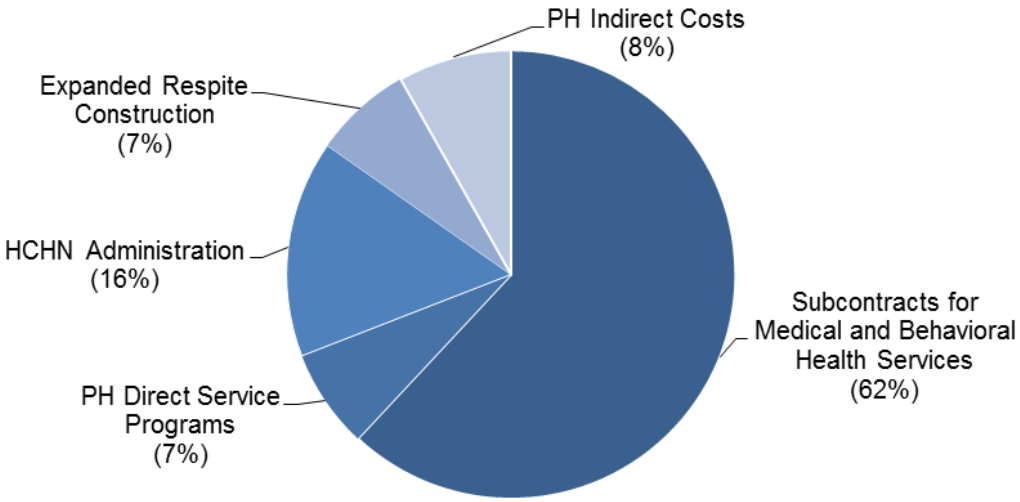
The HCHN budget increased by $1.9 million dollars in 2011 which included $911,000 in one-time capital funds and approximately $1 million in ongoing funds for contracted client services. The largest portion of new funding was for the Medical Respite program for renovation, move and start-up costs, and expansion of its client services and operations. The Medical Respite program expansion was supported by a HRSA American Recovery and Reinvestment Act grant (ARRA), funding from the Mental Illness Drug Dependency sales tax revenue (MIDD), United Way of King County, and new funding from a consortium of Seattle and King County hospitals. Starting in August 2011, federal New Access Point funding was awarded by HRSA to support the South King County Mobile Medical Van and the new Ballard Homeless Clinic. All the new funding except for ARRA capital funds continue in 2012.

Chart 2: HCHN total revenue 2011 ($9.2 million)



Charts 2 and 3 (right and below) display HCHN's revenue and expenses in 2011.

Chart 3: Expenses 2011 ($9.2 million)



Homeless clients served by HCHN contractors and PH sites

Table 1: Health Care for the Homeless demographic summary 2011

	HCHN sites	Public Health sites
Total visits	53,123	47,200
Unduplicated clients	9,609	11,523

		HCHN sites		Public Health sites	
		Number	%	Number	%
Age (years)					
	0 thru 5	394	4%	2,371	21%
	6 thru 10	141	1%	121	1%
	11 thru 13	111	1%	57	0%
	14 thru 17	281	3%	291	3%
	18 thru 24	999	10%	2,779	24%
	25 thru 34	1,384	14%	2,684	23%
	35 thru 59	5,287	55%	2,907	25%
	60 thru 74	955	10%	294	3%
	75 thru 84	52	1%	17	0%
	85+	5	0%	2	0%
	Total	**9,609**	**100%**	**11,523**	**100%**
Race					
	Asian	285	3%	656	6%
	Pacific Islander/Native Hawaiian	122	1%	280	2%
	Black/African American	2,342	24%	3,170	28%
	American Indian/Alaska Native	604	6%	396	3%
	More than 1 race/Other	791	8%	956	8%
	White	4,820	50%	3,977	35%
	Race unknown or not reported *	645	7%	2,088	18%
	Total - all races	**9,609**	**100%**	**11,523**	**100%**
Hispanic					
	Non-white race reported	339		150	
	White race reported	508		195	
	Race unknown or not reported *	560		1,731	
	Total Hispanic	**1,407**	**15%**	**2,076**	**18%**
Gender**					
	Male	5,719	60%	4,306	37%
	Female	3,890	40%	7,217	63%
	Total	**9,609**	**100%**	**11,523**	**100%**

Table 1: Health Care for the Homeless demographic summary 2011 (continued)

		HCHN sites		Public Health sites	
		Number	%	Number	%
Social unit					
	Family	1,720	18%		
	Individual (25+)	6,813	71%		
	Unattached youth (thru 17 yrs)	248	3%		
	Young adults (18 - 24 yrs)	828	9%		
	Unknown	0	0%		
	Total	**9,609**	**100%**		
Housing status					
	Street	910	9%	335	3%
	Shelter	3,462	36%	785	7%
	Transitional	716	7%	791	7%
	Doubled up	857	9%	2,762	24%
	Other	3,295	34%	6,848	59%
	Unknown	369	4%	2	0%
	Total	**9,609**	**100%**	**11,523**	**100%**
Insurance					
	Medicaid	3,570	37%	7,021	61%
	No insurance or unknown	4,617	48%	4,369	38%
	Other public insurance	155	2%	4	0%
	Medicare	1,065	11%	104	1%
	Private insurance	202	2%	25	0%
	Total	**9,609**	**100%**	**11,523**	**100%**

* Race: Hispanic/Non-Hispanic now reported as ethnicity, not race, in all federal reports
Race unknown + Hispanic = unknown race in federal reports
87% of clients served at HCHN sites which list "Race unknown" identify their race as Hispanic with no other information

** Gender: HCHN contracted data includes transgendered clients:
16 male-to-female and 8 female-to-male

Client characteristics - contracted services

Chart 4 (below) displays household status of HCHN clients in 2011. Nearly 40% of family members served by HCHN were children. Families tend to experience shorter episodes of homelessness than individuals. Chart 5 (below) displays the length of current episodes of homelessness in 2011.

Chart 4: Household status of HCHN clients 2011 (n = 9,609)

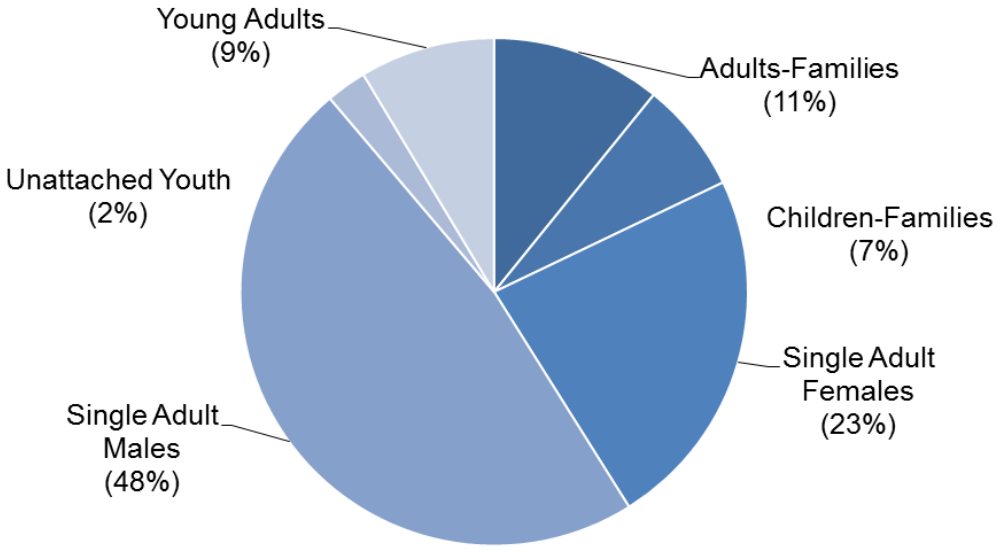
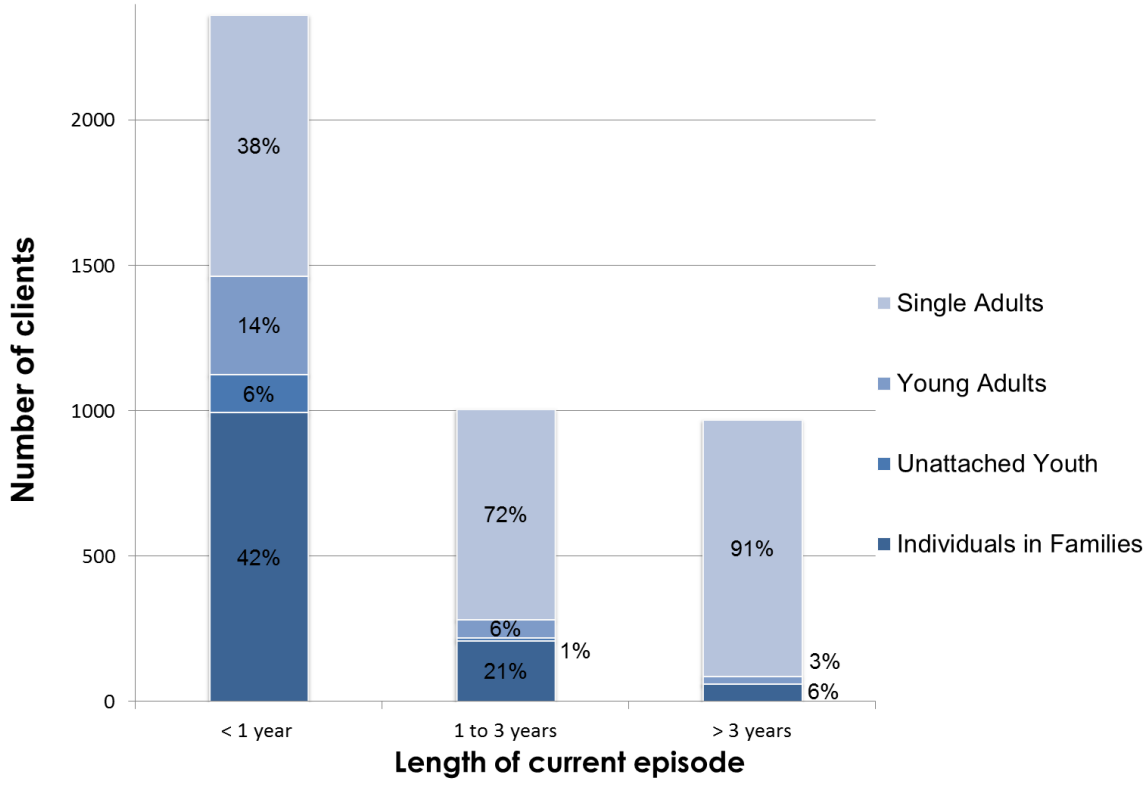


Chart 5: Length of current episode of homelessness 2011 (n= 4,336)



Homeless veterans served in HCHN programs

About 8% of adults served by HCHN were identified as veterans. The number of clients with veteran status is likely under-reported since this information is not always revealed in the first few visits with a client.

Veterans served by HCHN providers differ from non-veteran adults served by HCHN providers in two ways:

- Veterans were older on average
- Veterans were more likely to be insured than non-veterans

Turning theory into practice: **Client-centered care**

Andy, a Vietnam veteran, had a history of injection drug use, alcoholism, PTSD, and COPD. He was in extremely poor health, and had chronic ulcerative wounds on his legs and buttocks. Andy lived in a building with Housing Health Outreach Team (HHOT) nursing services. Over time he agreed to let the nurse look at his wounds and change his dressings. As his wounds slowly healed, he began to trust, open up and talk about his past, his nicotine, alcohol, and drug addiction. Although he didn't initially want to talk about going to the hospital, he eventually relented and made an appointment.

The hospital visit did not go well. Angry that his drug and alcohol use were addressed, and unhappy with the treatment plan, he refused further care and withdrew. After months of persistent and patient encouragement, he finally agreed to let the HHOT team physician advocate for additional hospital home health care for the terribly painful sores on his buttocks.

After weeks of care from with both the HHOT nurse and hospital in-home support, Andy is now healing and regaining strength. Andy's trust in the in-home VA nurse and HHOT nurse allowed him to discuss other health concerns and his desire to prevent another chronic wound. Andy decided that the best way to accomplish this was by establishing a primary care physician who could help guide his health care. Andy now uses the VA hospital system as his medical home. His treatment plan is supported by the HHOT nurse, and he is working with her on a smoking cessation plan. This coordinated team work and genuine patient-centered care prevented the need for a potentially lengthy hospitalization and allowed Andy to determine his own course of treatment.

Health problems

Table 2 (below) lists the five most common health problems documented by HCHN providers in 2011. The problems listed reflect those of clients seen by HCHN providers and are not necessarily representative of the homeless population in Seattle and King County. Health problems are reported by both medical and non-medical providers.

There were minor changes to the top five problems compared to 2010. Some of the variation may reflect changes in HCHN's provider pool. HCHN is increasingly focused on those who are the most vulnerable, not engaged in service, in need of behavioral health services, high utilizers of public health systems or jail, and those chronically homeless. For instance, four new MIDD providers were added in 2010, which may have resulted in mental health moving to the top of the list in two categories. The addition of a nurse to the REACH team who targets services to people with chronic addictions could have influenced the increase in encounters for people with substance abuse issues. The HHOT team grew in 2011, which could have increased the number of chronically homeless adults seen with complex and multiple health problems.

Not shown in this table is the difference in problems noted for those younger adults over age 25 and those adults middle aged and older. Among women over 55 years old, cardiovascular and endocrine disorders moved to be the second and third most common rankings. For men, cardiovascular problems moved to the top condition, and mental health to the third.

Table 2: Most common health problems noted by HCHN providers 2011

Rank	Females age 25+	Males age 25+	Children age 0 - 11	Youth age 12-17	Young adults age 18-24
1	Mental health	Mental health	Health maintenance	Health maintenance	Mental health
2	Substance related	Substance related	Respiratory	Mental health	Genitourinary
3	Skin conditions	Skin conditions	Skin conditions	Skin conditions	Health maintenance
4	Musculoskeletal	Cardiovascular	Mental health	Respiratory	Skin conditions
5	Respiratory	Endocrine	Musculoskeletal	Musculoskeletal	Substance related

Our programs

Featured program – downtown mental health team

Growing awareness of the impact of trauma led the Pioneer Square Clinic Downtown Mental Health team to arrange training in Seattle in the Trauma, Recovery and Empowerment Model (TREM) from Community Connections based in Washington, DC. Participants also included staff from Compass Housing Alliance and the REACH Program.

Because so many of the people encountered by HCHN providers are survivors of some form of trauma, the network's service approach is based on a model of trauma-informed care. Trauma comes in many forms, including poverty, community violence, personal violence, torture, war, loss of homeland, fear, homelessness, oppression, imprisonment, racism, and environmental degradation.

People may not disclose traumatic experiences for many reasons such as shame, lack of trust, or fear of revisiting the pain and they may not seek help for trauma in and of itself.

***Turning theory into practice:* trauma-informed care**

Sally's 57 years were marked by domestic violence, drug use, and alcohol abuse. In 2009, she abruptly left her violent husband with no money, no support, and no place to live. Sally wanted a life free of abuse and trauma, but she was sick, weak, and drained. She desperately needed help to create a better life for herself.

Fortunately, help arrived. Sally was accepted into a transitional housing program with supportive services on site. Here she could safely begin to address the damaging effects of violence and drug use.

In 2011, Sally was encouraged to participate in a Trauma and Recovery Empowerment Model (TREM) group. Slow to warm to the group, she silently listened to stories shared by others. After many weeks, she began to talk and noted that while she had limited recollection of early childhood experiences, she was able to connect certain events in her adult life to incidents she experienced in childhood.

Her TREM group has since ended and Sally is thriving. She moved into her first apartment and states that she has never before had the luxury of living in her own place where she is in control of who visits and how people are treated.

In the safe setting of the group, Sally was able to rediscover and trust her own thinking. She could accept the support and friendship of others who had similarly suffered and endured. She gained insight into the long term effects of trauma, and learned healthy ways to cope and heal.

Although individuals may report some details to their medical provider, they may not make the connection that trauma could be related to current problems they face. PTSD and a range of

symptoms including disassociation, addictive behaviors, emotional numbing, frightening flashbacks, depression, anxiety, hyper-vigilance, and a lack of trust in others commonly develop. Perhaps just as limiting is the profound sense of isolation, powerlessness, and unworthiness associated with traumatic experiences. This adapted sense of self can interfere with an individual's ability to access and use available resources.

The multidisciplinary group of trainees learned how to conduct groups based on the TREM principles. The first two groups were for women and lasted for six months. By the end of 2011, two more women's groups were started, and a men's group will begin soon. Groups meet weekly and participants have reported very positive experiences, as well as measurable reductions in their symptoms. Some members of the first group continue to meet for support and to further explore the TREM group concepts.

Expanded and new HCHN programs in 2011

Medical Respite – Edward Thomas House: Expanded respite program opens at Jefferson Terrace

Edward Thomas lived on Seattle streets and in shelters for two decades while cautiously avoiding contact with shelter staff and social service providers. Living with serious mental illness, Ed lived an isolated life, avoiding care and offers of help. Without a regular source of health care, Ed relied on hospital emergency rooms. In 2004, he entered Medical Respite to recover from leg wounds.

Ed's stay in Respite was a turning point in his life. Ed connected positively with Respite staff. They gave him a private space and brought music to share. His stay also offered him an opportunity to engage with a case manager who helped him connect with ongoing services and housing. Ed moved from Respite to his first apartment in 20 years. To this day, Ed remains stably housed, maintains a connection to his primary care physician, and has not been hospitalized or visited the emergency room since.

In September 2011, following four years of planning, the highly successful medical respite program moved from the William Booth and YWCA shelters — ending a 15 year era — and re-opened in a transformed model and location as the Edward Thomas House. Now located at Seattle Housing Authority's Jefferson Terrace residence, it is a free-standing, larger, and more versatile respite program. In its first six months of operation, 185 new patients were seen.

Medical respite provides safe recuperation services for homeless people who need further care after a hospital stay. The new program has succeeded in serving patients with a higher acuity of medical problems (such as those requiring IV antibiotics) and those with complex behavioral and psychiatric issues who the hospitals are unable to discharge elsewhere. Overall, the new program results in decreased lengths of stay for hospitalized patients experiencing homelessness. A Chicago study also showed that respite care reduces patients' future hospitalizations.[i]

***Turning theory into practice:* harm reduction**

Karla was discharged from the hospital after spinal fusion surgery which left her with severe right-sided paralysis. She came to Respite to receive intravenous antibiotics and recover from surgery. Prior to her operation, she had been homeless, sleeping outside, and struggling with heroin addiction.

During her 55 days at Respite, Karla worked hard to regain the use of her right side. Her addiction was managed with methadone and with the help of her case manager, she secured stable housing and became involved in an addictions support program.

Karla recently dropped by to visit the Respite program. Active in her addiction support program, she is now heroin-free, her paralysis is vastly improved, and she is actively engaged as a mother in her 16 year old son's life. She expresses her heartfelt thanks for her stay at Edward Thomas House, and readily credits her days in respite as the pivotal reason she has been able to make such dramatic changes.

Seventy-one percent of those admitted to Edward Thomas House in the first several months completed their treatment plan and respite stay, a significant improvement from the fewer than 50% in the program's earlier configuration. Providers credit the program's harm reduction philosophy, which optimizes engagement of those using alcohol or illicit drugs, the community environment, and the quality of the medical and behavioral health services. Also of note, 22% of those discharged in the first months were placed in stable housing, rather than being discharged back to the streets or shelters, and many were successfully placed in chemical dependency treatment programs.

[i] Buchanan D, Doblin B, Garcia P, Zerger S. Respite care for homeless people reduces future hospitalizations. *Journal of General Internal Medicine*, April 2003, Vol 18(S1), 203.

A unique community-wide resource, Medical Respite is a collaboration between Public Health, the King County Department of Community & Human Services, and multiple hospitals in King County. It is operated by Harborview Medical Center. Referrals from partnering hospitals, which provide financial support to the new program, continue to increase.

New Access Point - Ballard Homeless Clinic

In 2011, HCHN was awarded a HRSA New Access Point (NAP) grant to respond to unmet needs of the homeless population in the Ballard neighborhood of Seattle. In recent years, neighborhood sources, anecdotal, and quantitative data indicated an increased demand for services. Swedish Medical Center's Ballard Campus noted rising numbers of homeless clients utilizing the emergency department. Additionally, increasing trends of food bank utilization, demand for overnight shelters, public assistance utilization, and supportive housing demands indicated that there was a sharp increase in the number of homeless people seeking refuge. The lack of homeless-focused health services operating in Ballard further compounded the problem.

With the New Access Point grant, HCHN subcontracted funds to Neighborcare Health to staff and manage what is now called the Ballard Homeless Clinic. The clinic is temporarily located at St. Luke's Episcopal Church. In early 2013, the clinic will move to its permanent location on the second floor of the Nyer Urness House, a 79-unit supportive housing program under development by Compass Housing Alliance. Services include medical care, benefits assistance, case management, mental health services, chemical dependency services, and referral services to link patients to a regular primary care home.

New Access Point - South King County Mobile Medical Van

The 2011 NAP grant also provided funding to help stabilize the South King County Mobile Medical Program. The Mobile Medical Program began in late 2008 as a pilot project, supported by the King County Veterans and Human Services Levy, to address the need for health-focused outreach and engagement services to draw homeless adults into health care in South King County. Local levy funds were instrumental in helping leverage the new federal support.

The Mobile Medical Program improved access to medical, dental, and behavioral health services, and the need continues to exceed the capacity. The program provides integrated medical, dental, behavioral health, medical benefits assistance, and case management services at meal programs that routinely attract significant numbers of people who are unsheltered and chronically homeless. In 2011, a partnership with HealthPoint Community Health Centers and funding from HCHN

allowed for the addition of two social workers and one eligibility worker to provide key services on the van. A mobile dental van service accompanies the medical unit at some locations, and is supported with grants from the cities of Kent, Auburn, and Federal Way. More information about the mobile medical program is available at www.kingcounty.gov/health/mobilemed.

Program model and services

Caring for the health needs of homeless individuals in King County is a community-wide effort. Shelter, housing, and other social service and health care agencies collaborate to provide services where people are. Through HCHN, a community health center may provide nursing services at one site and provide mental health services at another. Staff of shelters and housing programs work closely with HCHN providers and assist with care coordination.

Common goals across HCHN-funded projects are connecting people to primary care services and ensuring coordination of care. Services reach the concentration of homeless individuals in downtown Seattle, as well as people dispersed throughout the county.

Facilitating access to medical coverage and care

An essential activity of all HCHN providers is to help people connect and reconnect to benefits such as Medicaid. Providers help clients access free and low-cost services such as medical, dental, mental health, and vision resources. The YWCA Health Care Access team and HealthPoint client service representatives have particular expertise in helping people enroll in public services throughout King County. Linkage to benefit coverage is also a key activity for many of HCHN's outreach services by the REACH team and the Mobile Medical project for example. Many of the complex clients served by both projects have benefitted from intensive engagement strategies to assist them in accessing and maintaining needed benefits.

***Featured practice:* preventing chronic health conditions**

In 2011, nurses at Carolyn Downs Family Medical Center prioritized helping families set self-management goals around physical activity and healthy eating. Health education was provided on nutrition, exercise, and ways to maintain a healthy body weight. Nurses from Carolyn Downs also collected swim suits for children so they could participate in pool activities at the YMCA in proper attire rather than in their clothes. As an additional support, one of the shelter sites began providing healthy produce every week through the on-site food bank. Many clients improved their food choices and increased their level of exercise as a result. For some that meant walking around the block, while others walked three to four times per week for 20 to 30 minutes. Four shelter clients began jogging, and one long term smoker remained nicotine free for at least six months. Without the nurses to provide education, support, and structure, many of these accomplishments would not have occurred.

Street outreach and case management

Evergreen Treatment Services' REACH team provides client-centered outreach and intensive case management services, engaging chronically homeless, chemically dependent adults. They focus on serving those who have multiple barriers to obtaining housing, including criminal background, prior evictions, complex health conditions, poor social and money management skills, a high degree of vulnerability and are unlikely to access resources independently. They link their clients to primary care, treatment, housing and entitlements. The REACH team includes nurses from Neighborcare Health who provide medical care out in the field, in shelters and on the streets.

Health services in shelters, day centers, and transitional housing

Historically, the core of HCHN services have been provided in shelter-settings, where it is easiest to connect with the greatest number of homeless individuals. Services have expanded greatly over the years to reach others.

Harborview's Pioneer Square Clinic provides medical and mental health services where people are residing in downtown Seattle. Nursing services that target Native American homeless adults are provided by Seattle Indian Health Board at Chief Seattle Club in downtown Seattle. For the past two years through MIDD funding, additional mental health providers from Harborview and Valley Cities Counseling & Consultation (VCCC) have helped 349 individuals discharged from jails, hospitals, and other institutions to connect to mental health and chemical dependency services throughout the county.

Families receive help addressing a wide array of issues from common childhood ailments and preventive care to the acute trauma of domestic violence. Families in Seattle and south King County are served by VCCC (mental health and chemical dependency). HealthPoint nurses span north, east, and south King County, while

Turning theory into practice: **client-centered care**

Sarah, 22, was raised "in a cult with everything being about the serving and pleasing the main guy." Physically, sexually and emotionally abused throughout her childhood, she "escaped by marrying the first guy [she] could - but he was even worse."

Wanting a better life for her two young children, Sarah escaped again by finding refuge in a shelter. She was determined to get her GED, find a job and raise her kids "normal."

Sarah had never received any medical care as a child and received very limited care as an adult, so she was uncertain and fearful about enrolling in primary care.

With the Neighborcare Health Family Team nurse's gentle encouragement, she agreed to see a doctor and establish a medical home for her family. She also made an appointment for herself. During the visit, Sarah was diagnosed with early stage cancer, but bravely followed-up with her referrals and treatment care plans. She is now housed, cancer- free and a proud mother of thriving children.

Neighborcare and Carolyn Downs provide nursing services in central and north Seattle. The Neighborcare family team also provides mental health care. Assuring access and stability in housing remains a first priority when assisting families.

Interdisciplinary services in supportive housing

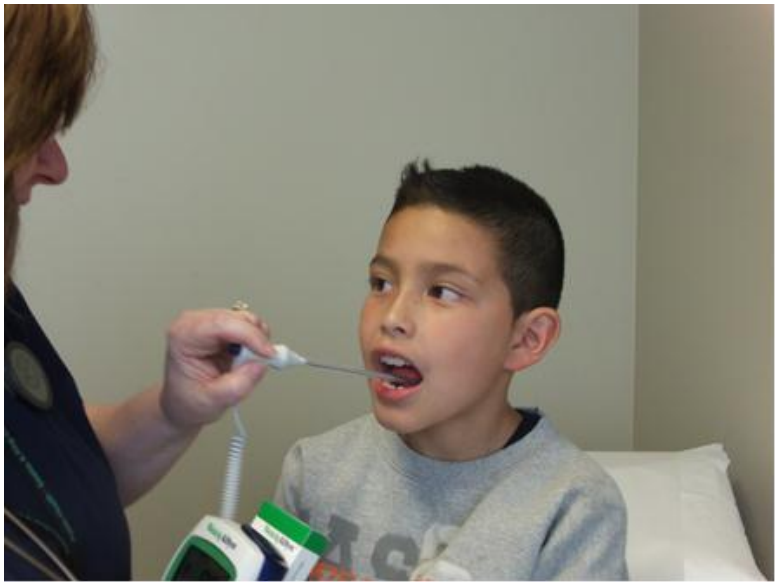
Once established in housing, years of harsh living, limited access to care, and behavioral challenges continue to impact people's health. Neighborcare, REACH, and HealthPoint providers address the health needs of formerly homeless adults. They assist with weekly medication boxes and monitor glucose, blood pressure, and respiratory conditions. The nurses have implemented walking groups, nutrition groups, and art groups to address triggers for relapse, in addition to instituting weight management and healthy cooking groups. They also bring additional medical services to sites such as regular foot care clinics, immunizations, wound care, and education about how trauma affects health and housing stability.

Clinics specialized for homeless individuals

HCHN also funds several clinics that are tailored to meet the needs of homeless clients, and are open at times and in locations that are the most easily accessible. Through early detection of health issues, providers are able to prevent worsening health and expensive emergency room visits.

Harborview Medical Center operates the Third Avenue Clinic, which provides essential medical care and mental health services for people as they transition into more stable primary care. Harborview also provides medical care at the Robert Clewis Center (formerly the Needle Exchange) which primarily includes treatment of skin infections, blood pressure monitoring, hepatitis and influenza vaccinations, TB skin tests, and assistance in establishing primary care.

Country Doctor Youth Clinic (operated by the University of Washington Adolescent Medicine Section) and Neighborcare Health's 45th Street Homeless Youth Clinic operate separate clinics for the very young homeless, from early adolescence through early 20's. Depending on the clinic, services include not only medical, dental, and behavioral health services, but also acupuncture, yoga, naturopathy, meditation, and massage.



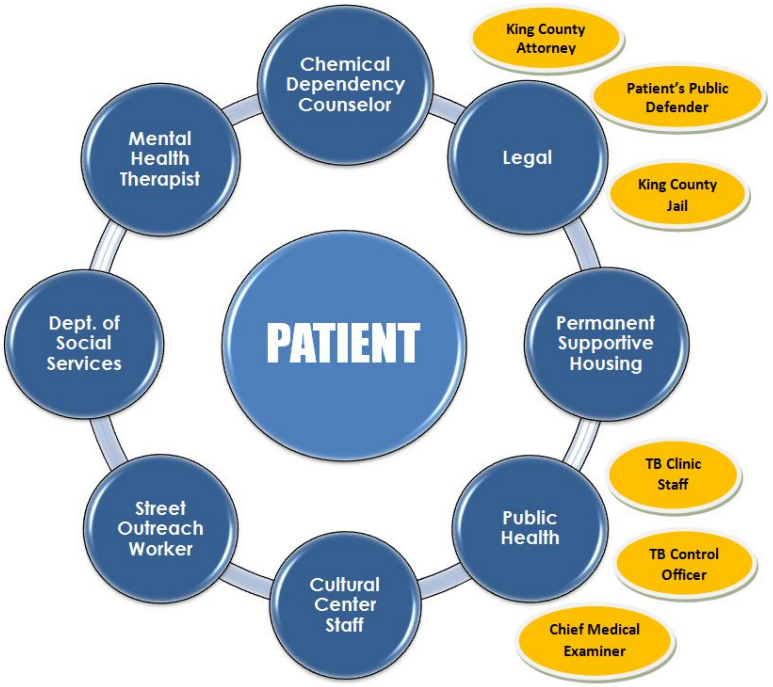
Additional HCHN funded clinics include, the South King County Mobile Medical Van, and the newly opened Ballard Homeless Clinic.

HCHN services through Public Health – Seattle & King County

Tuberculosis prevention

HCHN plays a key role in tuberculosis (TB) prevention in the homeless community in partnership with the TB Control Program. Through a grant from the City of Seattle, the HCHN TB prevention nurse meets with homeless service agencies to provide TB risk assessments and staff trainings and to ensure implementation of TB guidelines to prevent the transmission of TB. In 2011, over 300 staff of homeless service agencies received TB training. In addition, 10 homeless service programs representing both the public and nonprofit sectors convened for a TB and Homelessness Coalition meeting to discuss ongoing efforts to reduce the impact of TB in the homeless community.

Persons who are homeless and diagnosed with TB present with a variety of psychosocial barriers that interfere with their treatment adherence, including but not limited to, a lack of stable or permanent housing, legal issues, mental health issues, chemical dependency, and a lack of access to transportation. Such barriers contribute to higher program costs and lower treatment adherence rates. HCHN supports a social worker in the TB Control Program to assist TB patients who are homeless to find permanent housing. In 2011, 10 out of 11 of those TB patients remained in housing six months after completing treatment.



The diagram to the right demonstrates the complexity of coordinating care for one patient and the collaboration that was necessary among systems to house and treat the patient successfully. The social worker organized the team, led case conferences, and ensured the patient's needs were being met in each area. Although the patient had been living on the street for many years, through intensive efforts and close communication with the entire team, the patient was successfully housed during her treatment and remains housed 18 months after treatment completed.

Oral Health Program for homeless individuals

Public Health has increasingly prioritized services for homeless individuals at the Downtown Dental Clinic. The focus on homeless patients began through a federal grant that supports a partnership between the clinic and supportive housing programs, known as the VIP Dental Program. Through this partnership, the housing case managers refer tenants to the dental clinic and provide support to help them complete their dental treatment. The dental treatment that homeless clients receive at the Downtown Dental Clinic helps to alleviate one of the many problems that hinder their ability to transition out of homelessness. Due to the severity of dental problems, the clinic provided over 500 partial and complete dentures to homeless clients in 2011. For many, this has meant renewed hope and confidence to gain employment, which is the first step on the road out of homelessness.

In 2011, the Downtown Dental Clinic provided 8,677 client visits, which exceeded their original projected goal of 8,207 visits. Additionally, 52% of homeless clients completed their treatment plans within 12 months. One of the biggest challenges faced by the program is a growing demand for services in a climate of shrinking budgets and rising operating costs. Another issue is diminished access to resources in the community. The Public Health Downtown Dental Clinic remains a rare source for comprehensive dental care for a population who desperately need these services.

Quality improvement

HCHN contracted services

In 2011, HCHN quality improvement activities included a chart review visit to every HCHN contractor. Discussions were conducted regarding chart review policies and practices for HCHN charts, including the impact of the transition to electronic health records and suggestions for future training and support. In previous years, the administrative team reviewed charts directly and a report was sent to each agency. In 2011 the emphasis was on assuring that agency practices for chart review are in line with HCHN expectations. Wide variations were found in chart review practices across agencies. A summary of what was learned in these visits was sent to all contractors. The summary included practical recommendations for policies, records, and best practices for ongoing review of charts, including more utilization of case conferences and reviews to foster learning and support between peers.

Public Health services

According to the Centers for Disease Control, tobacco use is the biggest preventable cause of death and disease in the United States. Almost half a million Americans die each year from smoking-related illness and this is true with only 19% of the U.S. adult population smoking cigarettes.

The health implications amongst homeless persons are even more significant as an estimated 70 - 80% of homeless U.S. adults smoke cigarettes. Tobacco use is thought to be responsible for

almost half of the difference in mortality rates between adult men in the highest and lowest socioeconomic groups. The health effects of smoking are considerably worse for those living homeless than for the general public. Smoking both exacerbates many of the health conditions that people living homeless already have and research has shown that smoking increases anxiety and aggravates mental health conditions.

In 2011, HCHN collected tobacco-related data as part of the report for federal funding which supports Public Health's services to homeless patients. The measures asked:

1) How many homeless clients were asked about tobacco use during their clinic visits?
2) How many homeless tobacco users received a cessation intervention such as counseling?

- The rate of tobacco use assessment of homeless clients was 83% among clients receiving Public Health Center Primary Care, Family Planning, Dental or Parent-Child Health Support Services.

- The rate that homeless tobacco users who received cessation counseling was 80% among clients receiving Public Health Center Primary Care, Family Planning or Parent Child Health Support Services.

In the few months since the tobacco measures were collected and reviewed, Public Health Center programs have moved forward in several significant ways on tobacco cessation efforts with homeless clients. A decision was made to adopt a standard methodology of improvement. These standards include a) universal screening for tobacco use and electronic documentation of this assessment; b) electronic documentation of tobacco user status; and c) electronic documentation of the cessation intervention provided.

Plans to more thoroughly implement the use of a standard query and implement the Ask, Advice, Refer (2A's&R) intervention are underway. This intervention model is endorsed by WA DOH, CDC, and the National Cancer Institute. The dental program piloted tobacco training for dentists and assistants to refresh their use of motivational interviewing and the use of the 2A's&R model. The training will likely be spread to clinical teams in other Public Health programs; staff from the Public Health Tobacco Prevention Program have assisted with this work.

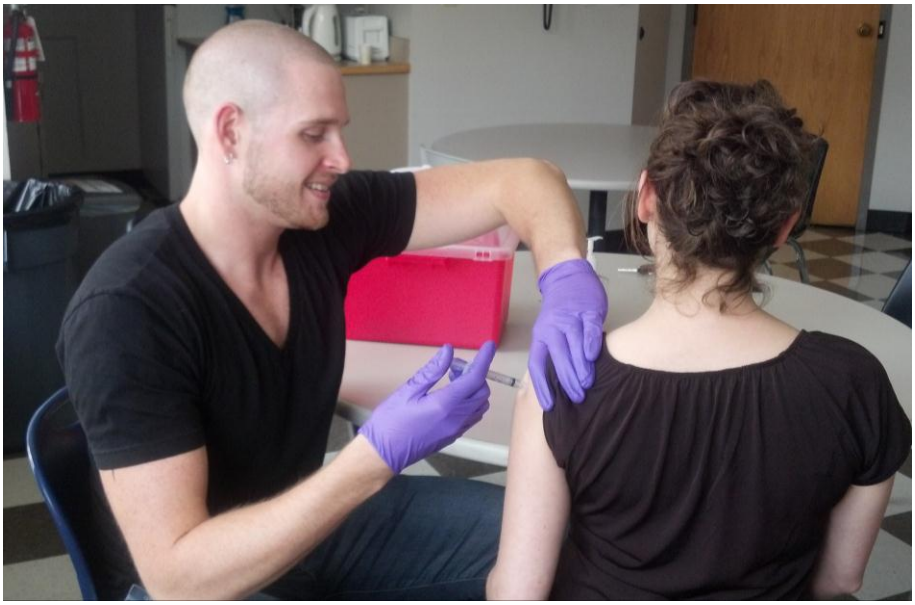
The U. S. Public Health Service Clinical Practice Guidelines state that "the first step in treating tobacco use is to identify tobacco users. The identification of smokers itself increases rates of clinician intervention." It is known from research that all clinicians are in a position to intervene with homeless patients who use tobacco, and Public Health Centers are moving forward on this work with a quality program for the improved health of those living homeless.

Public Health Reserve Corps (PHRC): an intra-departmental collaboration

The Public Health Reserve Corps (PHRC) is a group of local medical and non-medical workers who have committed to augment the work of Public Health programs as volunteers during a public health emergency or disaster. HCHN has collaborated with the PHRC for two and a half years on projects that respond to or prevent communicable disease or population wide issues. They have been involved in activities such as the ones listed below.

- Held flu vaccination “clinics” at service sites where homeless people spend time.
- Conducted surveys for City of Seattle and King County Metro about the health and social needs of homeless people and the impact of the termination of the Ride Free Area on low income and homeless people who sleep and use services in the downtown core.
- Assisted HCHN with the health screening area at United Way of King County’s Community Resource Exchange (also known as Project Homeless Connect).

In June 2011, HCHN provided training to sixteen PHRC volunteers in basic outreach and response to heat emergencies. Similar training is planned to respond to extreme cold weather related emergencies as well.



Public Health mobilized response to outbreak

In January 2011, a HHOT nurse from a supportive housing site requested advice from HCHN's Public Health and Safety nurse about several sick residents. The residents had diarrhea and vomiting, and two of them had been hospitalized that day.

Norovirus, which can cause severe diarrhea and vomiting and can remain viable for extended periods on environmental surfaces, was suspected. In settings such as this particular apartment building, norovirus can spread easily and can continue for several weeks after the first cluster is discovered. It can lead to dehydration, which is particularly dangerous for vulnerable people.

The HCHN Public Health nurse advised the HHOT nurse to track clients reporting symptoms, to assess for symptoms, and to advise people on how to maintain hydration and practice excellent hand hygiene. With over 200 residents in the building, the site nurse needed more help.

The HCHN Public Health nurse worked with the Communicable Disease/ Epidemiology section in the Health Department to enlist the assistance of the Public Health Reserve Corps (PHRC) and a group of nursing students who were doing a clinical rotation at the site. Volunteers and building staff were given a timely training on dealing with norovirus and the Public Health nurse gave the PHRC nurses a brief screening tool to assess residents for symptoms. Additionally, a letter was sent to all residents with norovirus information, asking them to contact the house manager or site nurse if they became symptomatic.

Non-nursing PHRC volunteers assisted with janitorial efforts to sanitize high-touch areas and post notices encouraging hand hygiene. The PHRC nurses and nursing students went door to door, performing wellness checks and leaving letters for the residents. Data was collected to document the scope of the problem.

Within days there was an abrupt cessation of complaints of norovirus symptoms, and no more residents were hospitalized. The building staff, residents and HHOT nurse were grateful for the Health Department's speedy and coordinated effort.

Questions about this report can be directed to:

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Appendix A: HCHN Planning Council members

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Judy Summerfield, City of Seattle Human Services Department

Hedda McLendon, Director of Programs, YouthCare

Sinan Demirel, Executive Director, Elizabeth Gregory Home

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Gregory Francis, Community Advocate, Co-chair

MJ Kiser, Program Director, Compass Center

Katy Miller, Homeless Housing Programs Coordinator, King County Housing and Community Development

Edward Dwyer-O'Connor, Sr. Clinic Practice Manager, Harborview Medical Center

Jennifer Perry, Veteran's Administration

Eva Ruiz, Community Advocate

Sheila Sebron, Veterans Advocate

Appendix B: HCHN-contracted service providers

Programs for families

Carolyn Downs Family Medical Center – Homeless Team: Nursing services to women and families in shelters and transitional housing sites in central Seattle.

HealthPoint: Nursing and benefits assistance to women and families in shelters and transitional housing sites in North, East and South King County.

Neighborcare Health/45th Street Clinic: Nursing and mental health services to women and families in shelters and transitional housing sites in North Seattle.

Valley Cities Counseling & Consultation: Mental health, chemical dependency and medical case management services to families in shelters, transitional housing in King County.

YWCA Health Care Access: Benefits assistance and linkage to medical care for women and families.

Programs for youth and young adults

Neighborcare Health/45th Street Clinic Homeless Youth Clinic: Medical clinic services to youth and young adults age 12-23 years.

University of Washington Adolescent Medicine Section/Country Doctor Teen Clinic: Medical clinic services to youth and young adults age 12-23 years.

Programs for single adults -

Evergreen Treatment Services/Housing Health Outreach Team: Chemical dependency services for formerly homeless adults living in supportive housing in Seattle.

Evergreen Treatment Services/REACH Program: Outreach and Engagement to people living outdoors in Seattle. Case management to chronically homeless and chemically addicted adults.

HealthPoint: Nursing services for formerly homeless adults living in units supported by Sound Mental Health in south King County.

Pioneer Square Clinic (Harborview Medical Center): Mental health and nursing services to adults in shelters, day centers, and transitional housing in Seattle.

Pioneer Square Clinic (Harborview Medical Center) / Medical Respite Program: Medical, case management, mental health and chemical dependency services for adults in King County.

Salvation Army/William Booth Center: Beds, meals and laundry services for the Medical Respite Program.

Seattle Indian Health Board: Nursing services at Chief Seattle Club.

Valley Cities Counseling and Consultation: Mental health and referral services to individuals living homeless in north, east, and south King County.

YWCA Angeline's: Beds, meals and laundry services for the Medical Respite Program.

Appendix C: HCHN major service sites

Single adults

- Catholic Housing Services – CHS (St. Martin de Porres Shelter)
- Chief Seattle Club
- Compass Housing Alliance (Adult Service Center, Hygiene Center, Women's and Men's Programs)
- Downtown Emergency Service Center (Shelter & 1811 Eastlake)
- Harborview Medical Center (Third Avenue Center at YWCA Opportunity Place)
- Jefferson Terrace/Edward Thomas House
- Katherine's House
- Markham Building
- PHSKC (Robert Clewis Center)
- Salvation Army (William Booth Center)
- Seattle Housing Authority (Jefferson Terrace)
- Sound Mental Health (Housing First in South King County)
- St. Luke's Episcopal Church (Ballard Homeless Clinic)
- YWCA (Angeline's Day Center and Downtown)

Housing Health Outreach Team (HHOT)

- Canaday House (DESC)
- Frye Apartments (LIHI)
- The Gatewood (Plymouth Housing Group-PHG)
- Humphrey House (PHG)
- Kerner-Scott House (DESC)
- The Lewiston (PHG)
- The Morrison (DESC)
- Noel House (CHS)
- Plymouth on Stewart (PHG)
- Rose of Lima (CHS)
- Scargo Apartments (PHG)
- Simons Apartments (PHG)
- The Westlake (CHS)
- The Wintonia (CHS)

Families

- Avondale Park
- Broadview Shelter
- Catherine Booth House (Salvation Army)
- Compass Housing Alliance (Adult Service Center, Hygiene Center, Women's and Men's Programs)
- Domestic Abuse Women's Network
- Eastside Domestic Violence Program
- Hopelink sites
- New Beginnings
- Providence Hospitality House
- Sacred Heart
- South King County Multi-Service Center sites
- Union Gospel Mission Family Shelter
- YWCA East Fir Street Shelter
- YWCA family sites countywide

Certain visits also take place in the client's home (once housed), streets, encampments, and other sites.

Youth and young adults

- 45th Street Youth Clinic (Neighborcare Health)
- Country Doctor Teen Clinic (through UW Adolescent Medicine Clinic)